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F 000	INITIAL COMMENTS The following deficiencies represent the findings of a partial extended complaint investigation #KS00056318.	F 000		
F 323 SS=F	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 49 residents. The sample included three current residents and one former resident. Based on observation, interview and record review, the facility failed to have a system in place to ensure each resident received adequate supervision to prevent accidents. Of the four residents sampled, two left facility grounds without supervision and without staff knowledge. Resident #1 left the facility in the evening hours without staff knowledge, remained out of the facility all night without staff awareness of his/her absence, and was later found deceased on the railroad tracks. Resident #2 stole a car and drove approximately 100 miles before being arrested by law enforcement. Additionally, 30 of 49 facility residents were allowed off facility grounds without supervision and without assessment of safety issues prior to allowing them to leave the	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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grounds.

Findings included:

- Resident #1's clinical record included a Face Sheet which noted readmission to the facility on 4/5/12 after hospitalization and a short stay at another area nursing home. Diagnoses listed on the face sheet included schizo-affective disorder - bipolar type, Klinefelter's syndrome, congestive heart failure, hypertension, coronary artery disease, diabetes mellitus, atrial fibrillation, Clostridium difficile, obesity, edema, tobacco disorder, hypokalemia, hypomagnesemia, anemia of chronic disease, chronic obstructive pulmonary disease, Vitamin B-12 deficiency, dental caries with pain, constipation, and urinary incontinence.

The clinical record did not include MDS (Minimum Data Set) information since the 4/5/12 readmission.

The 1/16/12 Quarterly MDS completed prior to resident #1's hospitalization and short stay at another area nursing home identified the resident with no speech problems, an ability to understand verbal communication, an inability to conduct a BIMS (Brief Interview for Mental Status) due to the resident "is rarely/never understood", no long or short term memory problems, moderately impaired decision making abilities, inattention, disorganized thinking, psychomotor retardation, acute onset mental status change, feelings of hopelessness/depression, short tempered and easily annoyed, the presence of hallucinations/delusions, no wandering behaviors, independence with ambulation and transfers, no balance problems, no range of motion limitations,

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no use of assistive devices, and use of antipsychotic medication on a daily basis.

The undated Admission/Daily Care plan for resident #1 contained basic information, including the resident's independence with eating, bathing, toileting and oral hygiene. According to this care plan, resident #1 had no "off grounds privileges."

A 4/5/12 Admission Nursing assessment for resident #1 included, "ambulatory ... coming from nursing home ...post surgery recovery....schizoaffective disorder...current smoker...weight 262 lbs [pounds], independent with ADLs [activities of daily living] ...alert and oriented."

Nurses Notes for resident #1 included:

o An entry on 4/5/12 at noon described resident #1's readmission to the facility from an area nursing home.

o An entry on 4/7/12 at 10:10 p.m. included, "....Resident would not come up for evening med pass. Res [resident] told the CNA [certified nurse aide], 'I am quitting all my meds. They're not helping me.' Res. has not been out of room since making this statement. [He/She] had been cooperative and pleasant until this episode of refusing all meds...."

o An entry on 4/9/12 at 6:00 a.m. included, "Unable to locate this resident. Have searched the facility and unable to find. Resident was in bed at first bed check at 12:00 a.m.. Resident was in bed at 2:00 but unable to locate resident when going to get [him/her] up. Searched each

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room and grounds. After searching et [and] calling our DON [Director of Nursing] this writer called the sheriff office et the officers came et searched. Staff members out searching."

Social Service Progress Note dated 4/9/12, the day after resident #1's elopement and the day of the resident's death included: "Resident is a readmit.....was readmitted on 4/5/12.....has a long history of psychiatric hospitalization for treatment for religious and paranoid delusions. ...had had a past history of suicidal thoughts without a plan...."

According to a 4/6/11 "KDOA [Kansas Department on Aging] Care Level II letter dated 4.6.2011 and updated on 9/13/11, "You [resident #1] will benefit by entering into a 24 hour structured/supervised nursing facility for stabilization/rehabilitation of your mental health condition....Your receiving nursing facility needs to be aware of your history of suicidal ideations, aggression and sexually inappropriate statements and develop with you a plan to keep you and others safe....."

According to the Weather Underground website, "wunderground.com", the outside temperature on 4/8/12 at 9:55 p.m. was 50.1 degrees Fahrenheit.

The facility's undated "Routine Resident Checks" policy directed staff to, "make routine resident checks to help maintain resident safety and well-being."

The facility's undated, "Wandering Residents" policy included, "All residents upon admission and as needed thereafter will be screened for a

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history of wandering.....Issues to be considered included mental or cognitive status changes, behavioral changes, ...". Additionally, the policy included, "All potential admissions to the facility will be screened per review of history and physical and interview with family/responsible party for history of wandering and conditions/diagnoses that indicate a potential for wandering.....On admission the facility will develop a plan of care for identified at risk residents..."

During an interview on 4/18/12 at 7:10 a.m., Direct Care Staff E confirmed he/she worked the 11 p.m. - 7 a.m. shift on the night of April 8 th, 2012. According to Staff E, two staff worked that night, him/herself and a charge nurse. Staff E reported neither staff member saw resident #1 during the entire 8 hour shift. Staff E confirmed the facility did not have a system in place prior to April 8, 2012 to ensure all residents were present and accounted for periodically. Staff E also reported prior to 4/8/12, the alarms to the front doors were rarely turned on, even during the night time hours. On the night of 4/8/12, Staff E confirmed the front door alarms were not turned on. According to Staff E, the front door alarms were left off to allow residents to come and go from the facility as they desired, because many of them liked to go sit on the front porch during the night. With only two staff on duty, Staff E confirmed there was no way to monitor the front doors continuously, therefore there was no way to know which residents went out the door or when they went out. Direct Care Staff E reported he/she first identified a problem with resident #1 missing from the facility at approximately 6:30 a.m., immediately notified the charge nurse of the

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resident's absence. Facility staff began a search of the building and grounds while other staff took their cars to go look for the resident. Staff E confirmed law enforcement personnel eventually found resident #1's deceased body on/near the railroad crossing at Main Street, approximately 1 block south of the facility. According to Staff E, resident #1 did not verbalize suicidal ideation or have delusional behaviors since readmission to the facility on 4/5/12.

During an interview on 4/18/12 at 12 noon, Licensed Nurse C reported he/she worked as the charge nurse on the 11 p.m. - 7 a.m. shift on 4/8/12. According to Nurse C, when resident #1's elopement first occurred, he/she recalled seeing the resident at midnight laying in bed. After thinking about it more, Nurse C decided he/she never actually saw the resident, but thought he/she was in bed because the blankets were bunched up at the foot of the resident's bed. Nurse C reported the front door alarms were turned off on the night on 4/8/12, just as on other nights. Nurse C confirmed two staff work the 11 p.m. - 7 a.m. shift, and both staff are frequently in other areas of the facility where they can not visualize the front doors. According to Nurse C, resident #1 could have left the facility at any time during the 11 p.m. - 7 a.m. shift without staff awareness of his/her exit from the building. Licensed Nurse C reported that Direct Care Staff E first advised him/her of resident #1's absence at approximately 6:30 a.m. on 4/9/12, and staff immediately began a search. When staff couldn't locate the resident in the building or on the facility grounds, they notified administrative staff. Licensed Nurse E verified law enforcement found resident #1's body on the railroad tracks near the

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Main Street crossing, where he/she had been hit and killed by a train. According to Licensed Nurse C, resident #1 did not talk of leaving the facility, verbalize suicidal ideation, or experience delusions since readmission to the facility on 4/5/12. Licensed Nurse C further confirmed that, prior to 4/8/12, the facility did not have a system in place to ensure residents were periodically present and accounted for throughout the day.

During interviews on 4/18/12 at 3:16 p.m. and 4/19/12 at 11:30 a.m., Administrative Nurse B confirmed resident #1 left the facility without staff knowledge on 4/8/12 and law enforcement personnel found the resident's body on/near the railroad tracks on the morning of 4/9/12. Nurse B reported resident #1 returned to the facility on 4/5/12 after hospitalization and a short stay at another nursing home. Facility policy did not allow residents to have off ground privileges within the first 30 days after admission, therefore resident #1 had no privileges to be off facility grounds without staff supervision. Administrative Nurse B confirmed the facility had no system in place to ensure resident #1 did not leave the grounds without staff knowledge/supervision. Nurse B also confirmed that prior to 4/8/12 the facility routinely left the front door alarms turned off during day and night time hours and therefore staff had no means to identify if/when residents entered or exited the facility. Nurse B also confirmed prior to 4/8/12, night shift were supposed to check on residents at least every two hours during their shift. Evening and day shifts had no expectations related to visualizing residents periodically to ensure they were present and accounted for.

During interviews on 4/18/12 at 7:45 a.m. and

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4/19/12 at 2:16 p.m., Direct Care Staff F reported the front door alarms remained turned off day and night prior to 4/8/12. According to Staff F, the facility has no way to know when residents come and go from the facility and/or facility grounds other than a notebook the residents are supposed to sign out in. Staff F also reported the facility has no system in place to ensure residents who do not have off grounds privileges remain in the facility or on the facility grounds. Staff F reported frequent observations of residents without off grounds privileges walking around town, and noted, "They see one of us and they usually just turn around and go right back to the facility."

During an interview on 4/18/12 at 8:45 a.m., Administrative Staff A reported the investigation into the incident of resident #1's elopement without staff knowledge and subsequent death, "identified a need for us to firm up our security system." Staff A reported the facility implemented a policy to ensure staff turn the front door alarms on at a set time every night and then turn them off at 5:00 a.m. every morning. Staff A confirmed the front door alarms remain disarmed from 5:00 a.m., throughout the day and evening hours, until either 10:30 p.m. or midnight depending on the night of the week.

During an interview on 4/24/12 at 3:00 p.m., Law Enforcement Officer G confirmed a highway patrolmen first discovered resident #1's body approximately 20 feet west of the Main Street crossing railroad tracks on 4/9/12 at approximately 8:00 a.m.. Officer G reported facility staff first advised him/her staff last saw the resident at 2:00 a.m. on 4/9/12, and later reported

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it might have been midnight when staff last saw the resident. After completing their own investigation, law enforcement staff determined staff did not see resident #1 since approximately 8:30 p.m. on 4/8/12, nearly 12 hours prior to when the highway patrolmen found the body on the railroad tracks. According to Officer G, he/she eventually identified the train that struck and killed resident #1, and it came through the Main Street crossing at 10:14 p.m. on 4/8/12. Subsequent review of the video recorded by that train confirmed resident #1 lay directly on the railroad tracks prior to being struck by the train. Law enforcement officer G reported his/her agency receives frequent calls from the facility to assist in locating residents who have, "walked off."

Observations on 4/17/12 at 6:30 a.m. revealed 8 facility residents on the front porch of the facility or on the front lawn or adjacent sidewalks. There were no staff observed in the area. Upon opening the main front doors leading into the facility, no alarm sounded. From the inside, alarms did not sound when staff/residents opened the front door to go outside.

Periodic observations on 4/18/12 from 6:30 a.m. - 5:00 p.m. and on 4/19/12 from 7:30 a.m. to 2:00 p.m. revealed facility residents moved at will in and out of the facility via the front doors. Door alarms did not sound when residents exited/entered the facility via the front doors.

The facility failed to have a system in place to ensure resident #1 and all other facility residents received adequate supervision to prevent accidents. Resident #1 left the facility in the evening hours without staff knowledge, remained

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out of the facility all night without staff awareness of his/her absence, and was later found deceased on the train tracks.

- Resident #2's clinical record included signed 3/29/12 physician's orders which identified the resident with diagnoses of disorganized schizophrenia, dermatophytosis of nail, ingrowing nail, esophageal reflux, dysphagia, myopia, astigmatism, constipation, hirsutism, heartburn, allergic rhinitis, disturbance of salivary secretions, and acne.

A 2/1/11 Quarterly MDS (Minimum Data Set) identified resident #2 with moderate cognitive impairment, feels down/depressed/hopeless, feels tired and has no energy; presence of hallucinations and delusions, no wandering behaviors, independence with ADLs (activities of daily living) including walking, and use of antipsychotics and antidepressants

A 6/20/11 Quarterly MDS identified resident #2 with moderate cognitive impairment, feels down/depressed/hopeless, feels tired and has not energy, presence of hallucinations and delusions, no wandering behaviors, independence with ADLs including walking, and use of antipsychotic and antidepressant medications.

Resident #2's current undated care plan identified the resident as an elopement risk and indicated no "off grounds privileges". According to the careplan, the resident should wear a Wanderguard alarm bracelet at all times.

Nurses Notes included the following entries:

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o 3/29/11 at 4:15 p.m.: "It was noted that res. [resident] was not in facility. Staff X 1 went to look for [him/her]. Res. was on main street south of facility by barbershop. Refused to return. Res. stated sister was at school et their souls are there, heads had been cut off so [he/she] had to go save their souls. Staff followed res. to high school. Res. refuses to return."

o 3/29/11 at 4:25 p.m.: Res. running towards train tracks 2 staff following. Res. turned around ran down Main St.[street] towards school. Res. stated had to get sister [name of sister] out of school. Tried to redirect. Explained school ended an hour ago and [his/her] sister was at facility. Res. stated [his/her] body is back at hospital but soul at top of school. Res. running around school trying to open doors. Res. with handful of hair stated to save sister soul. Staff X 2 walked res. to car to redirect fearful delusions regarding sisters [name of sisters] in school with heads cut off and their souls on top of school. Unable to get res. to get into car. Res. cont to look up at top floor with wide eyes. Called facility to notify unable to get res. back to facility. Cops called to put res. in protective custody."

o 3/29/11 at 5:00 p.m.: Officer arrived, talked with res., placed [him/her] in cuffs and put in police car. Unable to put in protective custody not harm to self/others but would sit with res. at facility."

o 8/6/11 at 6:30 p.m.: "...Has been very delusional this shift. Planning [his/her] wedding and asking our cook to fix a special dessert for [his/her] wedding. ....Active and in and out to walk..."

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o 9/3/11 at 5:00 p.m.: "Resident went to kitchen et [and] told them [he/she] wasn't going to eat supper...."

o 9/3/11 at 6:10 p.m. described an incident where a fellow resident told staff resident #2 left the facility grounds and walked north toward the church down the street. Documentation included, "....This res. [resident] walks around the block and in the front of the building and up and down the sidewalk and does a lot of walking every day. When resident did not return, this write called several staff members who live in town and asked help in returning res. to facility. Res. was dressed in summer clothes appropriate for the weather and made no indication that [he/she] was doing anything but going for [his/her] usual walk. Res. seemed calm and relaxed. This writer called our DON [director of nursing] and our Administrator and advised them of this. After thirty minutes passed and resident had not returned, Sheriff was called and resident father in [name of town] was called. Advised the father we would call as soon as we had any news. Officers took description of resident and were advised of circumstances.

o 9/3/11 at 7:30 p.m.: "Showed officer picture of resident and described [his/her] clothing. Officer assured staff they would notify us as soon as they had any information."

o 9/4/11 at 3:40 a.m.: "Resident remains eloped."

o 9/4/11 at 10:30 a.m.: "....Sheriff's office called and told RN [registered nurse] that [resident] had been found near [another town approximately 2

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hours away] and that they were going to get [him/her]."

Review of the clinical record revealed no evidence staff assessed for safety prior to allowing resident #2 continued off ground privileges when the resident exhibited delusional behaviors on 3/29/11 and 8/6/11, and no evidence staff immediately attempted to return resident #2 to the facility when the other resident advised staff of the resident walking off facility grounds near the church on 9/3/11.

The facility's undated "Routine Resident Checks" policy directed staff to, "make routine resident checks to help maintain resident safety and well-being."

The facility's undated, "Wandering Residents" policy included, "All residents upon admission and as needed thereafter will be screened for a history of wandering.....Issues to be considered included mental or cognitive status changes, behavioral changes, ...". Additionally, the policy included, "All potential admissions to the facility will be screened per review of history and physical and interview with family/responsible party for history of wandering and conditions/diagnoses that indicate a potential for wandering.....On admission the facility will develop a plan of care for identified at risk residents..."

During an interview on 4/18/12 at 11:30 a.m., Administrative Nurse B confirmed resident #2 left the facility and refused to return on 3/29/11 and then left facility grounds without staff knowledge

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on Saturday, September 3rd, 2011 without staff knowledge. Nurse B confirmed resident #2 had off grounds privileges on 3/29/11 and 9/3/11 even though the 2/1/11 and 6/20/11 MDS's both identified the resident with moderate cognitive impairment, multiple behaviors, and the presence of delusions and hallucinations. Nurse B recalled resident #2's off ground privileges were limited to Tuesdays and Thursdays for 30 minutes plus church prior to the 9/3/11 elopement. According to Nurse B, "I don't think [he/she] signed out but [he/she] wasn't talking off the wall so I guess I thought [he/she] was safe to be out alone." Nurse B also reported he/she didn't consider it an issue that the charge nurse failed to immediately attempt to return resident #2 to the facility grounds after another resident advised the nurse the resident headed north towards the church prior to the 9/3/11 elopement. Nurse B indicated residents do not have off grounds privileges for 30 days after admission or readmission, and residents earn those privileges through compliance with ADLs (activities of daily living), taking medications, and following their care plans. According to Nurse B, the facility currently does not evaluate safety prior to determining if a resident is appropriate for off grounds privileges. Nurse B confirmed the facility does not have a means to monitor resident compliance with off grounds privileges restrictions.

On 4/17/12 at 7:45 a.m., 2:00 p.m., 4:00 p.m. and 4/18/12 at 9:00 a.m., resident #2 wore a Wanderguard alarm bracelet on the wrist and ambulated independently within the facility. The resident appeared to respond to internal stimuli, and had the ability to give appropriate responses to basic questions.

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The facility failed to ensure resident #2 received adequate supervision to prevent accidents, including elopements, when staff failed to evaluate resident #2 for safety prior to allowing the resident off facility grounds without staff supervision,and failed to immediately respond to a fellow resident's report that resident #2 left facility grounds during a time the resident did not have privileges to be off the grounds.

- According to a "Resident List Report" dated 4/18/12, the facility had a census of 49 residents. On 4/18/12 at 9:00 a.m., Licensed Nurse D reviewed the list of residents and identified 24 of 49 residents with adequate cognitive abilities to complete an interview (interviewable).

The facility provided an "April 2012 Off Grounds" list which included the names of all residents allowed off facility grounds without supervision. That list contained the names of 30 residents, seven with unlimited privileges to be off facility grounds without supervision, and 23 with off grounds privileges twice weekly for 30 minutes.

A comparison of the lists of residents with "off grounds privileges" without staff supervision and the list of residents with the cognitive ability to complete an interview (interviewable) showed 11 residents with off grounds privileges lacked sufficient cognitive abilities to complete basic interviews.

A brief review of the most recent MDS (Minimum Data Set) information for each of the 30 residents allowed off facility grounds without staff

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supervision revealed the following:

o Staff completed a BIMS (Brief Interview for Mental Status) on only 4 of 30 residents and determined the remaining 27 lacked the ability to complete the interview.

o According to the most recent MDS assessments, 26 of the 30 residents allowed off facility grounds without staff supervision had, "moderately impaired" decision making abilities.

Although requested, the facility did not provide a policy for screening/assessment of residents prior to allowing the resident off facility grounds without staff supervision.

During an interview on 4/18/12 at 11:30 a.m., Administrative Nurse B confirmed many residents are allowed off facility grounds without staff supervision. Nurse B also confirmed some of the residents with off grounds privileges have active psychosis (delusions and/or hallucinations). According to Nurse B, just because a resident has significant cognitive impairment or impaired decision making abilities doesn't mean the residents wouldn't be able to find their way back to the facility, and therefore those cognitively impaired residents are allowed to leave the grounds without staff supervision. Administrative Nurse B also reported residents earn off grounds privileges by being compliant with staff requests for completion of ADLs (activities of daily living), taking prescribed medications and generally following their care plans. Nurse B reported the determination to allow residents off facility grounds without staff supervision does not

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include an assessment of safety factors/risks. Nurse B also confirmed the facility has frequent, "walk offs" which he/she described as a resident leaving the facility grounds when they weren't supposed to.

During an interview on 4/18/12 at 7:10 a.m., Direct Care Staff E reported the front door alarms "were never turned on" prior to 4/8/12, and residents could enter/exit the facility at will during the day or night time hours. According to Staff E, "We have no way of knowing where the residents are at any given moment. Most just like to go outside and sit on the front porch and if we're up front we can see them through the window."

During interviews on 4/18/12 at 2:16 p.m., Direct Care Staff F reported the front door alarms remained turned off day and night prior to 4/8/12. According to Staff F, the facility has no way to know when residents come and go from the facility and/or facility grounds other than a notebook the residents are supposed to sign out in. Staff F also reported the facility has no system in place to ensure residents who do not have off grounds privileges remain in the facility or on the facility grounds. Staff F reported frequent observations of residents without off grounds privileges walking around town, and noted, "They see one of us and they usually just turn around and go right back to the facility."

On 4/17/12 at 5:00 p.m., six residents sat on the front porch of the facility. Two residents walked on the sidewalk in front of the facility and one resident walked in the street directly north of the facility. One unknown male resident ambulated south on Main Street on the sidewalk near the

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F 323	Continued From page 17 grocery store and another male resident stood on the corner of the block south of Main Street talking with an unknown person. Observations on 4/18/12 at 8:00 a.m. revealed eight facility residents on the front porch of the facility or on the front lawn or adjacent sidewalks. There were no staff observed in the area. Upon opening the main front doors leading into the facility, no alarm sounded. From the inside, alarms did not sound when staff/residents opened the front door to go outside. The facility failed to have a system in place to ensure residents received adequate supervision to prevent accidents. The facility gave 30 residents privileges to go off facility grounds without supervision. The facility failed to assess for safety issues prior to giving those privileges to the residents. The facility also failed to ensure residents who did not have privileges to be off the grounds without supervision remained on facility grounds.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		

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F 425	Continued From page 18 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 49 residents, with 3 current and 1 former resident selected for sample. Based on observation, interview and record review, the facility failed to provide pharmaceutical services to 1 of 4 sampled residents in a manner that ensured timely administration of medications. (Resident #1) Findings included: - Resident #1's, "Face Sheet" noted re-admission to the facility on 4/5/12 with diagnoses of schizo-affective disorder - bipolar type, Klinefelter's syndrome, congestive heart failure, hypertension, coronary artery disease, diabetes mellitus, atrial fibrillation, Clostridium difficile, obesity, edema, tobacco disorder, hypokalemia, hypomagnesemia, anemia of chronic disease, chronic obstructive pulmonary disease, Vitamin B-12 deficiency, dental caries with pain, constipation, and urinary incontinence. The clinical record did not include MDS (Minimum Data Set) information since the 4/5/12	F 425		

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readmission.

The 1/16/12 Quarterly MDS completed prior to resident #1's hospitalization identified the resident with moderately impaired decision making abilities, inattention, disorganized thinking, psychomotor retardation, acute onset mental status change, feelings of hopelessness/depression, short tempered and easily annoyed, the presence of hallucinations/delusions, no wandering behaviors, and use of antipsychotic medication on a daily basis.

The undated Admission/Daily Care plan for resident #1 contained basic information, including the resident's independence with eating, bathing, toileting and oral hygiene. According to this care plan, resident #1 had no "off grounds privileges." The admission care plan did not include information related to the residents' mental illness, behaviors and/or use of psychoactive medications.

A 4/5/12 Admission Nursing assessment for resident #1 identified the resident as ambulatory, came from nursing home, post surgery recovery, schizoaffective disorder.

Transfer orders from the former nursing home included orders for multiple medications. Medications ordered for resident #1 included Coumadin 5 mg. (milligrams daily), Depakene 1000 mg. twice daily for moods/seizures, Olanzapine 10 mg. daily at bedtime for psychosis.

The Geriatric Dosage Handbook, 16 th edition, included the following information:

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o Pages 1873 - 1878 described Coumadin as an anticoagulant which increases the length of time it takes for blood to clot which should be administered at the same time daily.
o Pages 1835 - 1839 identified use of Depakene to treat seizures and mania associated with bipolar disorder.
o Pages 1276 - 1280 described Olanzapine (Zyprexa) as an antipsychotic used to treat agitation and mental disorders.

Nurses Notes included the following entries:

o 4/5/12 at noon: "This 63 year old [male/female] is being readmitted ...."

o 4/6/12 at noon: "Med list faxed to pharmacy"

The clinical record included no documentation related to facility failure to fax resident #1's medication list to the pharmacy until 24 hours after admission.

o 4/6/12 at 10:30 p.m.: "Meds not in yet from pharmacy"

o 4/7/12 at 4:40 p.m.(41 hours after resident #1's readmission to the facility) : "...All prescribed meds received from pharmacy..."

April 2012 MARs (medication administration records) documented staff failed to administer multiple doses of medications to resident #1 on 4/5/12 and 4/6/12. According to the MAR, resident #1 missed three doses of Depakene, two doses of Coumadin, and three doses of Olanzapine.

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F 425	Continued From page 21 During an interview on 4/18/12 at 8:45 a.m., Administrative Staff A confirmed the facility recently identified concerns related to staff failure to obtain and administer resident #1's medications in a timely manner after readmission on 4/5/12. During an interview on 4/27/12 at 10:10 a.m., Consultant H reported the facility should immediately fax medication orders to the pharmacy upon a resident's admission/readmission, and then the pharmacy would courier the medications to the facility within that same day. According to Consultant H, staff should have obtained medications, including Depakene, Zyprexa and Coumadin, for administration to resident #1 on 4/5/12, the date of admission. Consultant H confirmed staff failure to provide multiple doses of those medications was not in resident #1's best interests. On 4/17/12 at 7:30 a.m., residents lined up around the medication cart near the nurses station to receive medications. The facility failed to provide pharmaceutical services to resident #1 in a manner to ensure timely administration of medications after readmission to the facility.	F 425		